Employer's First Report of Accident

Virginia Worker's Compensation Commission
1000 DMV Drive Richmond VA 23220
See instructions on the reverse of this form

The boxes To the right are for the Use of the insurer	VWC file number	Reason for filing
	Insurer code	Insurer location
	Insurer claim number	

Employer

1. Name of employer	2. Federal Tax Identification Number	3. Employer's Case No. (if applicable)
4. Mailing address	5. Location (if different from mailing address)	
6. Parent corporation (if applicable)	7. Nature of business	
8. Insurer (name and location)	9. Policy number	10. Effective date

Time and Place of Accident

11. City of county where accident occurred	Did accident Occur on	12. Employer's premises? ❑ Yes ❑ No	13. State property? ❑ Yes ❑ No

14. Date of injury	15. Hour of injury	16. Date of incapacity	17. Hour of incapacity
18. Was employee paid in full of day of injury? ❑ Yes ❑ No		19. Was employee paid in full for day incapacity began? ❑ Yes ❑ No	
20. Date injury or illness reported	21. Person to whom reported	22. Name of other witness	23. If fatal, give date of death

Employee

24. Name of employee (Last, First, Middle)	25. Phone number	26. Sex ❑ Male ❑ Female
27. Address	28. Date of birth	29. Marital status ❑ Single ❑ Divorced ❑ Married ❑ Widowed
	30. Social security number	
31. Occupation at time of injury or illness	32. Department	33. Number of dependent children

34. How long in current job?	35. How long with current employer?	36. Was employee paid on a piece work or hourly basis? ❑ Piece work ❑ Hourly
37. Hours worked per day	38. Days worked per week	39. Value of prerequisites per week Food/Meals $ Lodging $ Tips $ Other $
40. Wages per hour $	41. Earnings per week (inc. overtime) $	

Nature and Cause of Accident

42. Machine, tool, or object causing injury or illness	43. Specify part of machine, etc.	were safeguards or safety equipment	44. Provided? ❑ Yes ❑ No
			45. Utilized? ❑ Yes ❑ No
46. Describe fully how injury or illness occurred			

48. Physician (name and address)	49. Hospital (name and address)	
50. Probable length of disability / 51. Has employee returned to work? ❑ Yes ❑ No	If yes / 52. At what wage? $	53. On what date?
54. EMPLOYER: prepared by (name, signature, title)	55. Date	56. Phone number
57. INSURERE: processed by	58. Date	59. Phone number

This report is required by the Virginia Worker's Compensation Act

First Report of Accident
VWC Form No. 3 (rev.10/1/91)

INSTRUCTIONS

Employer's First Report of Accident
VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. Please type or print all information in black ink. Your signature is required at the bottom of the form.

2. Send the original beige form to your insurance carrier or claims servicing agency for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.

3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.

4. If you need additional copies of this form, please request them from your insurance carrier or claims servicing agency.

Insurance carriers, self-insured employers, and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File, submit the original beige from and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.

2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.

3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission.

4. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternate versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.

The criteria are: (1) lost time exceeds seven days, (2) medical expenses exceed $1,000, (3) compensability is denied, (4) issues are disputed, (5) accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia workers' compensation commission.